



**INFORMED CONSENT TO  
HYSTEROSONOGRAPHY**

It is very important to Women’s Health Center of Lebanon that you understand and consent to the treatment your doctor is rendering and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

\_\_\_\_\_  
Patient's Initials or Authorized Representative                      Date

I, \_\_\_\_\_, hereby authorize Dr. \_\_\_\_\_ and any associates or assistants the doctor deems appropriate, to perform a hysterosonography (slow infusion of sterile saline solution into the uterus during ultrasound imaging). This procedure is also called a sonohysterography.

The doctor has explained the benefits of the procedure(s) to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s). I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

**Proposed Procedure:** During the procedure, we will insert a speculum into your vagina. We will swab your cervix with an antiseptic solution to make it sterile, and insert a small tube through the cervix into the cavity of the uterus. We will then gently introduce sterile saline (salt water) into the cavity of your uterus and take pictures with ultrasound to evaluate the cavity of the uterus.

**Risks/Possible Complications:** The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, bleeding, infection, and/or injury to the cervix or uterus. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases.

In permitting my doctor to perform the procedure(s), I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

**Alternative Procedures:** The reasonable alternative(s) to the procedure(s) have been explained to me. These alternatives include, but are not limited to: hysteroscopy (a procedure that allows the doctor to look at the lining of the uterus), endometrial biopsy (taking a small sample from the lining of the uterus), a dilation and curettage (enlarging and scraping of the uterus), or surgery. The risks of the alternatives include, but are not limited to: bleeding, infection, and/or injury to the cervix or uterus.

I consent to any photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them, so that my physician may follow my therapy progression. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date    Time    Signature of Patient or Authorized Rep.                      Relationship of Authorized Rep.

The Patient/Authorized Representative has read this form or had it read to him/her.

The Patient/Authorized Representative states that he/she understands this information

The Patient/Authorized Representative has no further questions.

The Patient/Authorized Representative has read the form in Spanish.

I certify that I have asked the patient/authorized representative the above questions and her responses were noted above.

\_\_\_\_\_  
Date                      Time                      Signature of Witness

**CERTIFICATION OF PHYSICIAN:**

I hereby certify that I have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

\_\_\_\_\_  
Date                      Time                      Signature of Physician

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**USE OF INTERPRETER OR SPECIAL ASSISTANCE**

An interpreter or special assistance was used to assist patient in completing this form as follows:

\_\_\_\_\_ Foreign language (specify)

\_\_\_\_\_ Sign language

\_\_\_\_\_ Patient is blind, form read to patient

\_\_\_\_\_ Other (specify) \_\_\_\_\_

Interpretation provided by \_\_\_\_\_

(Fill in name of Interpreter and Title or Relationship to Patient)

\_\_\_\_\_  
Signature (Individual Providing Assistance)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time